

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

to the replacement service. Other expenditures such as contracted management services, liability insurance, and legal consultants should also be classified as Direct Costs. The cost of psychiatrists and physicians, including the medical director, should be classified as Physician Costs. Also included in Physician Costs should be medical and neurological consultants and physician on-call coverage.

Ancillary service costs will be included by estimating charges for ancillary services provided to patients in replacement units and multiplying by the hospital-specific aggregate ancillary cost-to-charge ratio. This cost-to-charge ratio will be determined using the most recent RSC-403 ancillary costs adjusted to include capital expenses. Hospitals may not separately bill Medicaid for the professional component. The cost-to-charge ratio must be applied to all ancillary charges for services delivered to patients in replacement beds which customarily will include the following revenue codes:

Pharmacy (25x)  
IV Therapy (26x)  
Oncology (28x)  
DME (29x)  
Respiratory Therapy (41x)  
Physical Therapy (42x)  
Occupational Therapy (42x)  
Speech & Language Therapy (44x)  
Audiology (47x)  
Pulmonary Function Test (46x)  
Cardiology (48x)  
Osteopathic (53x)  
EKG (73x)  
EEG (74X)  
Gastrointestinal (75x)  
Observation or Treatment Room (76x)  
Lithotripsy (79x)  
Other Donor Bank (89x)  
Psychiatric Treatment (90x)  
Psychological Services (910, 911, 914-919)

TN 95-17  
Supersedes TN 94-20,  
TN 95-01, TN 95-10

Approval Date JUN 06 2001  
Effective Date 10/1/95

16b

**OFFICIAL**

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

General Classification - DX Services (920)  
Allergy Test (924)  
Other DX Services (929)  
Other Therapeutic Services (94x)

In addition to the costs described above, Indirect and Capital Costs will be allowed in the rate.

Allowable Indirect Costs will be those reported in the prior year RSC-403 inflated to the rate year. Indirect Costs and cost centers which will be reviewed include:

Administration	Nursing Administration
Plant Maintenance	Housekeeping
Plant Operations	Medical Records
Laundry and Linen	Social Services
Dietary	Medical Teaching
Cafeteria	Other (describe)

Capital costs include allocated costs for depreciation and interest associated with existing plant and equipment. In addition, the projected amortized costs attributable to renovations that are allowed in the contract will also be recognized as allowable Medicaid costs after being stepped down using the RSC-403 methodology. Major moveable equipment will be separately identified and directly costed to the replacement service in the same method used on the RSC-403. Upon determination of total Medicaid allowable costs, the state will project patient volume (days and discharges) by payor.

The Medicaid prospective per diem rate will, however, be subject to the following limit. Medicaid charges cannot exceed the amount that would be charged to other payors. Medicaid reimbursement, during an approved admission, will be limited to the lower of aggregate charges or the product of the per diem rate times the number of applicable Medicaid days for the replacement service.

TN 95-17  
Supersedes TN 94-20,  
TN 95-01, TN 95-10

Approval Date JUN 06 2001  
Effective Date 10/1/95

16c

**OFFICIAL**

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

Second Program Year and Subsequent Years

The Department will utilize the same process to calculate a prospective per diem rate for each hospital's second and subsequent program years. However, several cost categories will be updated to reflect actual cost experience in the prior year. These cost categories include:

1. Direct Costs - will be adjusted to reflect actual staffing patterns, overtime requirements, contracted expenses including management fees, and cost of supplies. Adjustments to and cost of the original direct care assumptions may be made at this time, and the adjusted costs will be updated for inflation.
2. Physician Costs - will be adjusted to reflect actual physician staffing, changes in compensation arrangements, on-call coverage requirements and inflation.
3. Ancillary Costs - will be adjusted to reflect prior year actual utilization levels and updates cost-to-charge ratios.
4. Major Moveable Equipment - will be updated to reflect actual expenditures.
5. Capital Costs - will be adjusted to reflect actual costs of approved renovations.
6. Indirect Costs - will be updated to reflect the most current RSC-403 Cost Report.

Upper Limit Adjustment and Federal Approval

Payment for DMH replacement units may be subject to an upper limit adjustment for any service year, based on an aggregate upper limit finding for all Medicaid acute hospital services.

TN 95-17  
Supersedes TN 94-20,  
TN 95-01, TN 95-10

Approval Date JUN 06 2001  
Effective Date 10/1/95

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

If any portion of the reimbursement methodology is not approved by the Health Care Finance (HCFA) the state will recoup any payment made to the hospital in excess of the approved methodology.

8. Outlier Payments

Eligibility

A hospital qualifies for an outlier per diem payment in addition to the standard payment amount if all of the following conditions are met:

- the length of stay for the hospitalization exceeds twenty (20) cumulative acute days (not including days in a distinct part psychiatric unit);
- the hospital continues to fulfill its discharge planning duties;
- the patient continues to need acute level care and is therefore not on administrative day status on any day for which an outlier payment is claimed;
- the patient is not a patient in a distinct part psychiatric unit on any day for which an outlier payment is claimed; and
- the patient is not a patient in a chronic unit (as described in Section IV.2.A.13) for which a chronic per diem has been established.

The outlier per diem payment amount is equal to fifty-five percent (55%) of the statewide average payment amount per day multiplied by the hospital's wage area index and casemix index, plus a per diem payment for the hospital's pass-through costs, direct medical education and capital payment amounts.

To derive the standard payment amount per day, the statewide average payment amount per discharge of \$2,706.10 is divided by the average FY90 Medicaid length of stay of 5.35 days, which equals \$505.81. The hospital-specific capital, direct medical education and pass-through per diem payments are derived by dividing the per discharge amount for each of these components by the hospital's Medicaid length of stay.

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

8. Outlier Payments

Eligibility

A hospital qualifies for an outlier per diem payment in addition to the standard payment amount if all of the following conditions are met:

- the length of stay for the hospitalization exceeds twenty (20) cumulative acute days (not including days in a distinct part psychiatric unit);
- the hospital continues to fulfill its discharge planning duties;
- the patient continues to need acute level care and is therefore not on administrative day status on any day for which an outlier payment is claimed;
- the patient is not a patient in a distinct part psychiatric unit on any day for which an outlier payment is claimed; and
- the patient is not a patient in a chronic unit (as described in Section IV.2.A.13) for which a chronic per diem has been established.

The outlier per diem payment amount is equal to fifty-five percent (55%) of the statewide average payment amount per day multiplied by the hospital's wage area index and casemix index, plus a per diem payment for the hospital's pass-through costs, direct medical education and capital payment amounts.

To derive the standard payment amount per day, the statewide average payment amount per discharge of \$2,706.10 is divided by the average FY90 Medicaid length of stay of 5.35 days, which equals \$505.81. The hospital-specific capital, direct medical education and pass-through per diem payments are derived by dividing the per discharge amount for each of these components by the hospital's Medicaid length of stay.

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

9. Transfer Per Diem Payments

a. Transfer Between Hospitals

In general, payments for patients transferred from one acute hospital to another will be made on a transfer per diem basis (capped at the per discharge payment) for the hospital that is transferring the patient. The amount of the transfer per diem payment is equal to the statewide average payment amount per day, multiplied by the transferring hospital's Medicaid casemix index and wage area index, plus pass-through, direct medical education and capital per diem payments.

To derive the standard payment amount per day for transfer patients, the statewide average payment amount per discharge of \$2,706.10 is divided by the FY90 average Medicaid length of stay of 5.35 days, which equals \$505.81. The hospital-specific capital, direct medical education and pass-through per diem payments are derived by dividing the per discharge amount for each of these components by the hospital's Medicaid length of stay.

In general, the hospital that is receiving the patient will be paid on a per discharge basis in accordance with the standard methodology specified in Sections IV.2.A.2, IV.2.A.3, IV.2.A.4 and IV.2.A.5, if the patient is actually discharged from that hospital. If the patient is transferred to another hospital, then the transferring hospital will be paid at the hospital-specific transfer per diem rate, capped at the hospital-specific per discharge amount. Additionally, "back transferring" hospitals will be eligible for outlier payments specified in Section IV.2.A.8.

An acute care hospital receiving a patient for medical or surgical services from a DMH Replacement Unit within another acute care hospital will be paid at its hospital-specific standard payment amount per discharge (SPAD). DMH Replacement Unit

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

rates are governed by separate contracts between hospitals, DMH and the Division.

Refer to matrices attached as Exhibit 2 for a review of transfer scenarios and corresponding payment mechanisms involving managed care recipients and non-managed care recipients in MH/SA network and non-network hospitals.

b. Transfers within a Hospital

In general, a transfer within a hospital is not considered a discharge. Consequently, in most cases a transfer between units within a hospital will be reimbursed on a per diem basis. This section shall outline reimbursement under some specific transfer circumstances. For a complete review of reimbursement under transferring circumstances involving managed care recipients and non-managed care recipients in MH/SA network and non-network hospitals, refer to the matrices attached as Exhibit 2.

(1) Transfer to\from a Chronic Unit within the Same Hospital

If a patient is transferred from an acute bed to the chronic unit in the same hospital, the transfer is considered a discharge. The Division will pay the hospital-specific SPAD for the portion of the stay before the patient is transferred to a chronic unit. In addition, the hospital will bill its hospital-specific chronic per diem for each chronic level of care (as defined in 130 CMR 435.409 attached as Exhibit 3) day that the patient is in the Chronic Unit.

TN 95-17  
Supersedes TN 94-20,  
TN 95-01, TN 95-10

Approval Date JUN 06 2001  
Effective Date 10/1/95

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

(2) **Medicaid Payments for Newly Eligible Recipients or in the Event of Exhaustion of Other Insurance**

When a patient becomes Medicaid-eligible or other insurance benefits have been exhausted after the date of admission and prior to the date of discharge, the acute stay will be paid at the transfer per diem rate, up to the hospital-specific SPAD, or, if the patient is at the administrative day level of care, at the AD per diem rate.

(3) **Admissions Involving One-Day Length of Stay Following Surgical Services**

If a patient who requires hospital inpatient services, is admitted for a one-day stay following outpatient surgery, the hospital shall be paid at the transfer per diem rate instead of the hospital-specific SPAD.

(4) **Transfer between a Distinct Part Psychiatric Unit and Any Other Bed within the Same Hospital**

Reimbursement for a transfer between a distinct part psychiatric unit and any other bed within a hospital will vary depending on the circumstances involved, such as managed care status, MH/SA network or non-network hospital, DMH replacement bed, or the type of service provided. Please refer to the appropriate matrix in Exhibit 2 for reimbursement under specific transfer circumstances involving psychiatric stays.

TN 95-17  
Supersedes TN 94-20,  
TN 95-01, TN 95-10

Approval Date JUN 06 2001  
Effective Date 10/1/95

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

(5) Change of Managed Care Status during a  
Psychiatric or Substance Abuse  
Hospitalization

(a) Payments to hospitals without network  
provider agreements with the Division's  
Mental Health/Substance Abuse (MH/SA)  
Provider.

When a recipient becomes assigned to managed care during a non-emergency or emergency psychiatric or substance abuse stay at a non-network hospital, the portion of the hospital stay during which the recipient was assigned to managed care shall be paid by the Division's MH/SA provider at the transfer per diem rate, capped at the hospital-specific SPAD, for substance abuse services, or at the psychiatric per diem rate for mental health services. The portion of the hospital stay during which the recipient was not assigned to managed care will be paid by the Division at the psychiatric per diem rate for psychiatric services or at the transfer per diem rate for substance abuse services, capped at the hospital-specific SPAD.

(b) Payments to hospitals with network  
provider agreements with the Division's  
MH/SA Provider.

When a patient becomes assigned to managed care during an emergency or non-emergency psychiatric or substance abuse hospital stay, the portion of the hospital stay during which the recipient was assigned to managed care shall be paid by the Division's MH/SA provider at the per diem rates agreed

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

upon by the hospital and MH/SA provider.

The portion of the hospital stay during which the recipient was not assigned to managed care will be paid by the Division at the psychiatric per diem for psychiatric services or at the transfer per diem rate for substance abuse services, capped at the hospital-specific SPAD.

10. Physician Payment

For physician services provided by hospital-based physicians to Medicaid inpatients, the hospital will be reimbursed in accordance with, and subject to the Physician Regulations at 130 CMR 433.000 et seq. (attached as Exhibit 4). Such reimbursement shall be at the lower of the fee in the most current promulgation of the Rate Setting Commission fees as established in 114.3 CMR 16.00 (Surgery and Anesthesia Services), 17.00 (Medicine), 18.00 (Radiology) and 20.00 (Clinical Laboratory Services)<sup>1</sup>, or the hospital's usual and customary charge.

Hospitals will be reimbursed for such physician services only if the hospital-based physician took an active patient care role, as opposed to a supervisory role, in providing the inpatient service(s) on the billed date(s) of service.

Hospitals shall not be reimbursed for inpatient physician services provided by community-based physicians.

11. Payment Rates for Inpatient Hospital Services Provided by Health Maintenance Organizations (HMOs)

---

<sup>1</sup>These regulations are voluminous, and will be provided upon request.

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

Except for the following components, the methodology described in Section IV.A shall apply to the rates for HMOs contracting with the Division:

- A separate casemix index shall be calculated for disabled recipients (as defined in Section II) and applied to the statewide average payment amount per discharge. This will result in a distinct and separate per discharge rate, outlier rate and transfer rate which shall apply to disabled recipients enrolled in HMOs.
- A separate casemix index shall be calculated for non-disabled recipients (all other categories of assistance) and applied to the statewide average payment amount per discharge. This results in a distinct and separate per discharge rate, outlier rate and transfer rate which shall apply to all Medicaid recipients enrolled in HMOs, except disabled recipients (as defined in Section II).

If an HMO offers to pay a hospital a rate equivalent to that hospital's applicable RFA rate for services to the HMO's Medicaid enrollees, that hospital is required to accept the HMO's rate offer as payment in full for those enrollees.

This requirement does not preclude an HMO from choosing to pay any hospital at a rate higher or lower than the hospital's applicable RFA rates for services to the HMO's Medicaid enrollees.

12. Payments for Administrative Days

Payments for administrative days will be made on a per diem basis as described below. These per diem rates are all-inclusive and represent payment in full for all AD days in all acute care hospitals.

- The AD rate is comprised of a base per diem payment and an ancillary add-on.
- The base per diem payment is the average nursing home rate for acuity categories six to ten,

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

effective January 1, 1992, as determined by the Massachusetts Rate Setting Commission. This base rate is \$107.92.

- The ancillary add-on is based on the ratio of ancillary charges to "room and board" charges, calculated separately for Medicaid/Medicare Part B eligible patients and Medicaid-only eligible patients on AD status, using Medicaid claims for the period October 1, 1991 to September 30, 1992.

These ratios are 0.0665 and 0.2969, respectively. The resulting AD rates (base and ancillary) were then updated for inflation using the update factors of 3.01% for RY94, 2.80% for RY95, and 3.16% for RY96.

- The resulting AD rates are \$125.72 for Medicaid/Medicare Part B eligible patients and \$152.87 for Medicaid-only eligible patients.

A hospital may receive outlier payments for patients who return to acute status from AD status after 20 cumulative acute days in a single hospitalization. That is, if a patient returns to acute status after being on AD status, the hospital must add the acute days preceding the AD status to the acute days following the AD status in determining the day on which the hospital is eligible for outlier payments. The hospital may not bill for more than one SPAD where the patient fluctuates between acute status and AD status; the hospital may only bill for one SPAD (covering 20 cumulative acute days), and then for outlier days, as described above.

13. Chronic Per Diem

If in the FY90 base year, a hospital had a designated Chronic Unit of twenty-five (25) beds or more within the hospital, a chronic per diem was calculated. When a patient is admitted directly to a chronic unit, a hospital must bill the hospital-specific chronic per diem. There will be no outlier payments for patients in

TN 95-17  
Supersedes TN 94-20,  
TN 95-01, TN 95-10

Approval Date \_\_\_\_\_  
Effective Date 10/1/95

JUN 05 2001

OFFICIAL

**Attachment 4.19A(1)**

**State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement**

chronic units. This rate is based on the hospital's actual costs (as reported on the FY90 RSC-403) for chronic services delivered to Medicaid recipients. This rate shall be paid for every day that is considered chronic level of care according to the regulations as stated in the Chronic Disease and Rehabilitation Inpatient Hospital regulations at 130 CMR 435.409 et seq. (attached as Exhibit 3).

This per diem is all inclusive and represents payment in full for all chronic services. The derivation of the chronic per diem is as follows:

- (a) A routine Cost-to-Charge Ratio (CCR) was calculated using routine chronic costs from the FY90 RSC-403, less major moveable equipment, divided by routine chronic charges from the FY90 RSC-403.
- (b) The result was multiplied by the Medicaid chronic routine charges from the FY90 Medicaid claims data file to obtain routine Medicaid costs.
- (c) The routine costs were added to the ancillary chronic Medicaid costs (which were also derived from the ancillary CCR, multiplied by FY90 Medicaid chronic ancillary charges) to obtain the total Medicaid chronic costs.
- (d) The total Medicaid chronic costs were divided by FY90 Medicaid chronic days (from the Medicaid claims data file) and added to the updated FY91 hospital-specific capital pass-through amount to arrive at the chronic per diem. The per diem was updated using inflation factors of 3.35% to reflect price changes between RY92 and RY93; 3.01% to reflect price changes between RY93 and RY94; 2.80% to reflect price changes between RY94 and RY95; and 3.16% to reflect price changes between RY95 and RY96.

TN 95-17  
Supersedes TN 94-20,  
TN 95-01, TN 95-10

Approval Date JUN 06 2001  
Effective Date 10/1/95

**OFFICIAL**

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

14. Infant and Pediatric Outlier Payment Adjustments

a. Infant Outlier Payment Adjustment

In accordance with 42 U.S.C. §1396a(s), the Division will make an annual infant outlier payment adjustment to acute hospitals for inpatient hospital services furnished to infants under one year of age involving exceptionally high costs or exceptionally long lengths-of-stay.

(1) Data Source - The prior year's claims residing on the Division's Medicaid Information System shall be used to determine exceptionally high costs and exceptionally long lengths of stay.

(2) Eligibility - Eligibility for the Infant Outlier Payment Adjustment shall be determined as follows:

(a) Exceptionally Long Lengths of Stay: The statewide weighted average Medicaid inpatient length of stay shall be determined by dividing the sum of Medicaid days for all acute care hospitals in the state by the sum of total discharges for all acute hospitals in the state. The statewide weighted standard deviation for Medicaid inpatient length of stay shall also be calculated, according to the following formula:

$$\sqrt{\frac{\sum \left( \frac{\text{MA Discharges}}{\text{Average MA Discharges}} - \frac{\text{MA Days}}{\text{MA Discharges}} \right)^2}{N}} = \sqrt{\frac{\sum \text{MA Days}^2}{\sum \text{MA Discharges}^2}}$$

Where N= number of acute hospitals in Massachusetts,

MA= Medicaid, and

Average Medicaid discharges= statewide Medicaid discharges divided by N.

TN 95-17  
Supersedes TN 94-20,  
TN 95-01, TN 95-10

Approval Date JUN 09 2001  
Effective Date 10/1/95

OFFICIAL

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

The statewide weighted standard deviation for the Medicaid inpatient length of stay shall be multiplied by two, and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers shall be each hospital's threshold for Medicaid exceptionally long length of stay.

(b) Exceptionally High Cost: For hospitals providing services to individuals under one year of age the Division shall:

(i) First, calculate the average cost per Medicaid inpatient case for each hospital;

(ii) Second, calculate the standard deviation for the cost per Medicaid inpatient case for each hospital; and

(iii) Third, multiply the hospital's standard deviation for the cost per Medicaid inpatient discharge by two and add that amount to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers shall be each hospital's threshold for Medicaid exceptionally high cost.

(c) Eligibility for an Infant Outlier Payment Adjustment: For each hospital providing services to individuals under one year of age, the Division shall: first, calculate the average Medicaid inpatient length of stay involving individuals under one year of age. If this hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

Section IV.A.14.a(2)(a), then the hospital shall be eligible for an outlier adjustment in the payment amount. Second, calculate the cost per inpatient Medicaid case involving individuals under one year of age. If a hospital has a Medicaid inpatient case with a cost which equals or exceeds the hospital's own threshold defined in Section IV.A.14.a(2)(b), then the hospital shall be eligible for an outlier payment adjustment.

- (d) Infant Outlier Payment to Hospitals: Each hospital that qualifies for an infant outlier payment adjustment shall receive an equal portion of \$50,000. For example, if two hospitals qualify for the adjustment, each shall receive \$25,000.

b. Pediatric Outlier Payment Adjustment

In accordance with 42 U.S.C. §1396a(s), the Division will make an annual pediatric outlier payment adjustment to acute hospitals for inpatient hospital services furnished to children greater than one year of age and less than six years of age if provided by a hospital which qualifies as a disproportionate share hospital under Section 1923(a) of the Social Security Act. (See Federally-Mandated Disproportionate Share Adjustment, Section IV.C.2 for qualifying hospitals.) The payment shall be calculated as follows:

- (1) Data Sources - The prior year's claims residing on the Department's Medicaid Information System shall be used to determine exceptionally high costs and exceptionally long lengths of stay.

TN 95-17  
Supersedes TN 94-20,  
TN 95-01, TN 95-10

Approval Date \_\_\_\_\_  
Effective Date 10/1/95

OFFICIAL

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

(2) Eligibility - Eligibility for the Pediatric Outlier Payment Adjustment shall be determined as follows:

- (a) Exceptionally Long Lengths of Stay:  
The statewide weighted average Medicaid inpatient length of stay shall be determined by dividing the sum of Medicaid days for all acute care hospitals in the state by the sum of total discharges for all acute hospitals in the state. The statewide weighted standard deviation for Medicaid inpatient length of stay shall also be calculated, according to the following formula:

$$\sqrt{\frac{\sum \left( \frac{\text{MA Discharges}}{\text{Average MA Discharges}} \right)^2}{N} - \left( \frac{\sum \text{MA Days}}{\sum \text{MA Discharges}} \right)^2}$$

Where N= number of acute hospitals in Massachusetts,  
MA= Medicaid, and  
Average Medicaid discharges= statewide Medicaid discharges divided by N.

The statewide weighted standard deviation for the Medicaid inpatient length of stay shall be multiplied by two, and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers shall be each hospital's threshold figure for Medicaid exceptionally long length of stay.

- (b) Exceptionally High Cost: For hospitals providing services to individuals greater than one year of age and less than six years of age, the Division shall:

TN 95-17  
Supersedes TN 94-20,  
TN 95-01, TN 95-10

Approval Date JUN 05 2001  
Effective Date 10/1/95

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

- (i) First, calculate the average cost per Medicaid inpatient case for each hospital;
  - (ii) Second, calculate the standard deviation for the cost per Medicaid inpatient case for each hospital; and
  - (iii) Third, multiply the hospital's standard deviation for the cost per Medicaid inpatient discharge by two and add that amount to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers shall be each hospital's threshold Medicaid exceptionally high cost.
- (c) Eligibility for a Pediatric Outlier Payment: For each hospital which qualifies under Section IV.C.2 and provides services to individuals greater than one year of age and less than six years of age, the Division shall: first, calculate the average Medicaid inpatient length of stay involving individuals greater than one year of age and less than six years of age. If this hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in Section IV.A.14.b(2)(a), then the hospital shall be eligible for a pediatric outlier payment adjustment. Second, calculate the cost per inpatient Medicaid case involving individuals greater than one year of age and less than six years of age. If a hospital has a Medicaid inpatient case with a cost which equals or exceeds the hospital's own threshold defined in Section IV.A.14.b(2)(b),

TN 95-17  
Supersedes TN 94-20,  
TN 95-01, TN 95-10

Approval Date JUN 06 2001  
Effective Date 10/1/95

OFFICIAL

Attachment 4.19A(1)

State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement

then the hospital shall be eligible for a pediatric outlier payment adjustment.

- (d) Pediatric Outlier Payment to Hospitals:  
All hospitals qualifying for a pediatric outlier payment adjustment will share, in equal allotments, one half of one percent of the total funds allocated for payment to acute hospitals under the Basic Federally-Mandated Disproportionate Share Adjustment described in Section IV.C.2. The total funds allocated for payment to acute hospitals under the Basic Federally-Mandated Disproportionate Share Adjustment described in Section IV.C.2 will be reduced by the payment amount under this section.

B. Reimbursement for Unique Circumstances

1. Sole Community Hospital

The standard inpatient payment amount per discharge for a sole community hospital (as defined in Section II) shall be equal to the sum of:

97% of the hospital's estimated actual FY90 cost per discharge, adjusted for casemix and inflation; and the hospital-specific pass-through amount per discharge, direct medical education amount per discharge and the capital amount per discharge.

Derivation of estimated actual FY90 Medicaid costs is described in Section IV.A.2.

Adjustments were made for casemix by dividing the FY90 cost per discharge by the hospital's FY90 casemix index and then multiplying the result by the hospital's casemix index.

Adjustments were made for inflation by multiplying the casemix-adjusted payment amount by 3.35% to reflect

TN 95-17  
Supersedes TN 94-20,  
TN 95-01, TN 95-10

Approval Date JUN 9 6 2001  
Effective Date 10/1/95

**Attachment 4.19A(1)**

**State Plan Under Title XIX of the Social Security Act  
State: Massachusetts  
Institutional Reimbursement**

inflation between RY92 and RY93; by 3.01% to reflect inflation between RY93 and RY94; by 2.80% to reflect inflation between RY94 and RY95; and by 3.16% to reflect inflation between RY95 and RY96.

Any acute hospital that qualifies as a sole community hospital and had fewer than 50 Medicaid admissions in FY90 shall be exempted from the casemix adjustment to its hospital-specific payment amount per discharge.

There will also be outlier payments for patients whose length of stay during a single hospitalization exceeds twenty acute days.

Acute hospitals which receive payment as sole community hospitals shall be determined by the Division.

TN 95-17  
Supersedes TN 94-20,  
TN 95-01, TN 95-10

Approval Date JUN 06 2001  
Effective Date 10/1/95

**OFFICIAL**